Welcome To Village Dental of Milford

~ About Your Child ~

Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Male __ Female __

Address: _____ City/State/Zip: _____

Referred by: _____

~ Responsible Party/Parent Information ~

Name: _____ Relation to the Child: _____

Date of Birth: _____ Social Security Number: _____

Address (if different than child): _____

Phone: (_____) _____ Email: _____

~ Insurance Information ~

PRIMARY

Subscriber: _____ Date of Birth: _____

Social Security Number: _____ Relation to child: _____

Employer: _____ Employer Phone: (_____) _____

Insurance Company: _____ Policy/Contract #: _____

Insurance Co. Phone: (_____) _____

SECONDARY

Subscriber: _____ Date of Birth: _____

Social Security Number: _____ Relation to child: _____

Employer: _____ Employer Phone: (_____) _____

Insurance Company: _____ Policy/Contract #: _____

Insurance Co. Phone: (_____) _____

Reason for today's visit: _____

Check all that apply:

__ Tooth pain/sensitivity
__ Stained teeth
__ Broken/Chipped tooth
__ Teeth grinding
__ Gum discomfort
__ Lost/Broken fillings
__ Loose tooth
__ Blisters/sores in or around mouth

Habits we should know about: _____

~ Dental History ~

	YES	NO
Does your child brush his/her teeth daily?	_____	_____
Do you assist your child?	_____	_____
Is dental floss used?	_____	_____
Is fluoride used in any form?	_____	_____
Has your child had Orthodontic treatment?	_____	_____

How is your child's overall attitude about dental? _____

Last dental exam? _____

Last dental x-rays? _____

Previous dentist: _____ Phone: (_____) _____

~ Child's Medical History ~

Please list any medications your child is taking: _____

Has your child had surgery? _____

Is your child allergic to:

__ Latex __ Novocaine __ Penicillin/Amoxicillin __ Aspirin

__ Other: _____

Please check all that apply to your child:

__ Anemia	__ Diabetes	__ Liver/Kidney
__ Asthma	__ Hearing Problems	__Seizures/Epilepsy
__ Bladder	__ Heart Murmur	__ Tonsillitis
__ Cancer/Tumors	__ Hepatitis	__ Other: _____
__ Cerebral Palsy	__ High/Low Blood Pressure	
__ Chronic Sinus	__ HIV/AIDS	

We invite you to discuss with us any questions regarding your child's dental health. The best dental services are based on a friendly, mutual understanding between provider and patient.

I understand the above information and have completed the form to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided. I authorize the release of any medical information to insurance companies or for legal documentation. I understand that I am responsible for all fees for treatment regardless of my insurance coverage.

_____ _____

Signature of parent or legal guardian Date